



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AUSTIN RADIOLOGICAL ASSOCIATION
PO BOX 4099
AUSTIN TX 78765

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

STANDARD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-1480-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Austin Radiological Association has provided services in good faith to a patient who presented as an injured employee and Worker's Compensation Claimant..."

Amount in Dispute: \$3761.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for medical dispute resolution should be dismissed under rule 133.307(e)(3)(H) and (J), as the claimant's injury has been determined to not be compensable. ...the Carrier investigated the claimed injury, and disputed the compensability of the injury. A Contested Case Hearing was held on 01-10-2011, and the Hearing Officer determined the injury was not compensable. A copy of the Decision and Order is attached. As the injury is not compensable, the Provider is not entitled to reimbursement."

Response Submitted by: Travelers; 1501 S Mopac Expressway; Suite A-320; Austin TX 78746

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| May 11, 2010 | A9579, 70553, 82565, 72156 | \$3761.00 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §413.042 (a)(1) sets out the procedures for health care providers to pursue a private claim against an injured employee.

Issues

1. Has the compensability of this claim been finally adjudicated?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent submitted a copy of a Contested Case Hearing that was held on January 10, 2011 to determine the compensability of the claimant's injury. The hearing officer ruled that the injured employee did not sustain a compensable injury in the course and scope of his employment. Division records indicate that the Contested Case Hearing was appealed and the Appeals Panel affirmed the hearing officer's decision which became final on April 15, 2011.
2. Texas Labor Code §413.042 states in pertinent part that "(a) A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless: (1) the injury is finally adjudicated as not compensable under this subtitle..."
3. The requestor is not entitled to reimbursement by the respondent as the injured employee did not sustain a compensable injury in the course and scope of his employment.

Conclusion

For the reasons stated above, the requestor has failed to establish that reimbursement is due and medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 28, 2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.